Please complete this form as accurately and completely as possible. Please print.

Today's Date	
Patient's name (Last, First, MI)	
Patient's Date of Birth	
Patient's SS#	
Patient's Street Address	
Patient's City, State, Zip Code	
Contact Phone Number	
Email Address	
Emergency Contact Name	
Emergency Contact Phone Number	
Date of Patient's Last Eye Exam	
Type of Contact Lens Worn (If Any)	☐ Soft ☐ RGP ☐ Scleral ☐ CRT ☐ Other
Patient's Primary Care Physician	
Patient's Occupation	
Patient's Gender	
Patient's Race	
Patient's Ethnicity	☐ Hispanic or Latino ☐ Not Hispanic or Latino
Patient Height & Weight	feet| inches| pounds

Primary Insurance Info (patients must provide both vision and medical insurance cards)

	Carrier	Subscriber's name	DOB	Relationship to pt	Insurance ID#
Vision					
Medical					

Responsible Party Billing Info: ☐ Check this box if the billing info is the same as above

Name	
Street Address	
City, State, Zip Code	
Phone Number	
Email Address	

Our office participates with various vision and medical insurance plans. Most vision plans are only intended for routine eye exams. Please note that eye exams that are intended for and/or result in a medical diagnosis may need to be filed with your medical insurance. The type of insurance plan needed for the exam can only be determined at the conclusion of the exam, therefore our staff must collect information regarding both vision and medical plans before the exam. Our office makes every effort to verify the amount owed by the patient at the day of the exam. However, the exact amount of patient's responsibility can only be determined by the insurance company once the claim has been filed. If this amount differs from the amount charged on the exam date, the patient will be sent a bill for the remaining balance (or a refund in case of overpayment). Patient is also responsible for payment of services denied or otherwise not paid by his/her insurance company in a timely manner.

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Patient's Name Signature of patient (or parent if patient is under 18)

Please indicate if you (the patient) or an immediate family member ever had the following.	**Patient**		**Family**	
Ocular History	Yes	No	Yes	No
Eye surgery?				
Eye trauma?				
Cataracts?				
Glaucoma?				
Macular degeneration?				
Other eye disease (cancer, retinal detachment, etc.)?				
ROS / Medical History	Yes	No	Yes	No
Flashes, floaters, double vision, eye pain, vision loss, other eye/vision problems?				
Any type of cancer (other than eye)?				
Recent fever for more than 10 days, unexpected weight change, fatigue?				
(Females) currently pregnant and/or nursing?				
Genital/urinal problems (discharge, pain, blood in urine, kidney disease, etc.)?				
Gastrointestinal/liver problems (abdominal pain, hepatitis, etc.)?				
Psychiatric problems (depression, anxiety, etc.)?				
Endocrine problems (diabetes, high/low thyroid, etc.)?				
Ear, nose, mouth/throat problems (sinus problems, hearing loss, dry mouth, etc.)?				
Allergic, immunologic problems (seasonal allergies, food allergies, etc.)?				
Skin problems (excessive dryness, rashes, psoriasis etc.)?				
Cardiovascular problems (palpitations, high blood pressure, heart disease, etc.)?				
Musculoskeletal problems (joint pain, swollen joints, arthritis, etc.)?				
Respiratory problems (coughing, sleep apnea, COPD, asthma, bronchitis, etc.)?				
Blood, lymph problems (high cholesterol, anemia, HIV/AIDS, etc.)?				
Neurological problems (frequent headaches, stroke, etc.)?				
Other conditions not mentioned above?				
Social History	Yes	No	Yes	No
Alcohol use?				
Tobacco use (current or past)?				

Please list all current medications, including eye drops and non-prescription medications.

Please list all allergies to medications.

Patient's Name Signature of patient (or parent if patient is under 18)

Automated Visual Field Consent

Automated visual field screening is a technologically advanced method recommended by the doctor to assess both central and peripheral field of vision for major defects. It is specially useful in detecting certain types/stages of glaucoma, brain tumors, aneurysms, strokes, and other ocular/neurological disorders. It may also help the clinician in determining causes of unexplained headaches. The test is non-invasive and takes approximately 1 minute per eye.

The out of pocket cost for the test is $25.

☐ *Please check here if you (the patient) would like to have the automated visual field screening.*

Contact Lens Fitting Consent (Skip if the patient is not being prescribed contact lenses.)

I understand that contact lenses are medical devices and prescribing them requires a higher level of professional judgment and liability than a standard comprehensive exam, therefore there is an additional fee to have a contact lens prescription which may or may not be covered by my (the patient's) insurance plan. I understand that contact lenses shall not be dispensed to me or worn by me unless I am trained on proper insertion, removal, and care of them. I understand that the contact lens evaluation fee covers up to three follow visits as needed within 90 days of the initial fitting. I understand that contact lens prescription can not be finalized until the appropriate trial period and necessary follow ups are completed. I understand that wearing contact lenses comes with complications such as inflammation and infections which have the potential of causing temporary or even permanent vision loss. I understand that such risks are significantly higher for extended wear of contact lenses, therefore contact lenses must be taken out and properly stored before sleeping. I understand that I must inform the doctor if I plan to sleep in contact lenses so I can be fitted in the right type of contact lens. Other factors that increase the risk of complications included improper care of contact lenses, not replacing disposable contact lenses based on the recommended schedule, and swimming/showering in contact lenses. I understand that if I experience symptoms such as redness, irritation, eye pain, burning, reduced vision, and/or other ocular complications that I must discontinue contact lens wear right away and follow up with my eye doctor or the emergency room as soon as possible.

☐ *Please check here if you (the patient) would like to be fitted for contact lenses.*

Correspondence Consents

Please list all individuals whom we may share your medical and related financial info with

Name	Relationship to Patient	Phone Number

☐ **Please check here to authorize Brown's Eye Center to release your (the patient's) medical information to the office of your primary care physician.**

I authorize Brown's eye center to contact me via (mark all that apply):

☐ phone ☐ text message ☐ email

With regards to medical and related financial information, if I am not able to answer the phone, I authorize Brown's Eye Center to (mark all that apply):

☐ leave a detailed message ☐ leave a message asking me to return the call

☐ send me a text message ☐ send me an email

☐ leave a message with a person I have authorized sharing my info with

Patient's Name

Signature of patient (or parent if patient is under 18)